CONNECTICUT JUDICIAL BRANCH
OFFICE OF VICTIM SERVICES

Please detach this page and keep it for future reference.

APPLICATION AND ELIGIBILITY REQUIREMENTS FOR VICTIM COMPENSATION

- A victim of crime who has suffered personal injury
- The family member of a sexual assault, child abuse or homicide victim
- The person financially responsible for a victim's medical expenses
- The person financially responsible for a homicide victim's funeral expenses
- The parent/guardian of a homicide victim's child
- A person financially dependent on a homicide victim
- The designated decision maker of a homicide victim.

You may be an eligible applicant of the Connecticut Victim Compensation Program.

ELIGIBILITY REQUIREMENTS:

1. The crime should be reported to police within five days of the personal injury or death.
   - If the crime was not reported within five days, the Office of Victim Services must evaluate the reason for the delay.
2. The application for compensation should be filed with the Office of Victim Services within two years of the date of the personal injury or death.
   - A waiver of the two-year requirement is available in certain circumstances. For eligibility information, call the Office of Victim Services.
3. The victim must have suffered personal injury or death as a result of the incident.
4. The personal injury victim must cooperate with police and other law enforcement agencies in their efforts to apprehend and prosecute the offender(s).
5. The victim's behavior must not have contributed to the criminal incident.
6. There must be at least $100.00 of "out-of-pocket" expenses for medical and/or dental treatment, mental health counseling, prescriptions, lost wages, and/or funeral expenses after insurance and other collateral sources (public assistance, Medicare, Medicaid, Workers' Compensation, etc.) have been paid.

Filing an application for compensation is not a promise from this office that you will receive a compensation award. The Office of Victim Services will investigate and evaluate your application before making a decision.

COVERED EXPENSES:

1. The cost of medical and dental treatment, including hospital, doctor, dentist, ambulance, x-rays, prescription medication and other similar treatment.
2. The cost of medical treatment/mental health counseling for victims and for family members of child abuse, sexual assault, homicide victims, and the designated decision maker of a homicide victim.
3 Lost wages of personal injury victims, including overtime and self-employment income.
4. Funeral expenses of homicide victims and loss of support for the children, financial dependents and the designated decision maker of homicide victims.
5. Future treatment, including mental health counseling and plastic surgery, which may be awarded after the initial compensation award.

Property loss, property damage, pain and suffering, attorney fees and any non-economic loss are not compensable.

HOW TO FILE YOUR APPLICATION

1. Please complete as much of the application as possible. If you have any questions while filling out this form, do not hesitate to call the Office of Victim Services at **(860) 747-4501** or toll free in Connecticut at **1-888-286-7347**.
2. You do not need to be represented by an attorney to file an application. However, you have the right to obtain an attorney if you wish. Note: If you have attorney representation, the attorney may take up to 15% of the award as a fee. No additional compensation is awarded for attorney fees.
3. Type or print clearly **in ink**. Do not use pencil.
4. Attach additional sheets if necessary.
5. **Family Members**: Each family member of a child abuse, sexual assault, or homicide victim who needs compensation for his/her own medical or mental health counseling expenses **must file his/her own application**. Each application is evaluated separately, but is part of the victim's claim.
   Designated Decision Maker: The designated decision maker of a homicide victim who needs compensation for his/her own medical or mental health counseling expenses **must file his/her own application**. Each application is evaluated separately, but is part of the victim's claim.
6. Fill in Section 2 Claimant Information if any of the following situations apply:
   a. You are the parent or legal guardian of a personal injury victim who is a minor (under 18 years of age) or who is incompetent.
   b. You are a family member of a child abuse, sexual assault, or homicide victim and are applying for compensation for your own medical or mental health counseling expenses.
   c. You are applying for compensation for funeral expenses.
   d. You are applying for compensation for loss of support as the family member, or designated decision maker of a homicide victim.
7. You can help the Office of Victim Services process your application by sending the following information:
   a. Civil Action Information A copy of the complaint. If you have settled with a third party, a copy of settlement and name, address and phone number of your attorney.
   b. Employment Information If you are self-employed, a copy of your income tax return or other record of earnings for the year before the crime and the year of the crime.
   c. Medical/Counseling Information Itemized medical, dental and/or counseling bills.
   d. Insurance and Other Collateral Source Information If applicable, "Explanation of Benefits" statements from medical insurance, and the settlement on an auto insurance claim.
   e. Funeral Expenses The funeral bill and a copy of the death certificate.
   f. Loss of Support For a child, a copy of the child's birth certificate and, if applicable, Social Security Benefit statement. For a spouse, a copy of the marriage certificate. If an estate for the deceased has been opened, a copy of the Appointment. For a designated decision maker, a document that has been executed by the victim in accordance with CGS 1-56r.
8. **All applicants must sign** Section 13 Statement of Facts and Authorization **in the presence** of a person authorized to take acknowledgments in the State of Connecticut. Such persons include a Notary Public, an attorney admitted to the State bar, a Justice of the Peace, a Judge, a Clerk or Deputy Clerk of the court, or a Town Clerk.
   NOTE: The person taking the acknowledgment must sign and date the form **on the same date** as the applicant.
9. Send your application to the Office of Victim Services, 31 Cooke Street, Plainville, CT 06062.

ADA NOTICE

The Judicial Branch of the State of Connecticut complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation in accordance with the ADA, contact the Office of Victim Services.

SOCIAL SECURITY DISCLAIMER

The disclosure of your Social Security number is voluntary. It is not required in order for the Office of Victim Services to process your application. Employees at Victim Services use the Social Security number to identify applicants and their medical and other records when processing applications. The Office of Victim Services is given the authority to investigate claims in Section 54-208(c) of the Connecticut General Statutes.

APPLICATION FOR VICTIM COMPENSATION

JD-VS-8 Rev. 9/99

CONNECTICUT JUDICIAL BRANCH

OFFICE OF VICTIM SERVICES

31 Cooke Street, Plainville, CT 06062

TELEPHONE (860) 747-4501 or **TOLL FREE 1-888-286-7347**

FOR OFFICE USE ONLY
CLAIM NO.
CLAIM EXAMINER

SECTION 1 VICTIM INFORMATION

NAME OF VICTIM *(Last, First, and Middle)*	HOME TELEPHONE NO. HOME FAX NO.	WORK TELEPHONE NO.	
CURRENT ADDRESS	CITY	STATE	ZIP CODE
ADDRESS AT TIME OF INCIDENT	BIRTHDATE	AGE	SEX
SOCIAL SECURITY NO.	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED		

SECTION 2 CLAIMANT INFORMATION *(Complete if different from victim)*

NAME OF CLAIMANT *(Last, First, and Middle)*	HOME TELEPHONE NO. HOME FAX NO.	WORK TELEPHONE NO.	
ADDRESS	CITY	STATE	ZIP CODE
RELATIONSHIP TO VICTIM	BIRTHDATE	AGE	SEX
SOCIAL SECURITY NO.	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED		

SECTION 3 CONTACT PERSON *(Person to contact if victim/claimant cannot be reached)*

NAME OF CONTACT PERSON *(Last, First, and Middle)*	HOME TELEPHONE NO. HOME FAX NO.	WORK TELEPHONE NO.	
ADDRESS	CITY	STATE	ZIP CODE

SECTION 4 ATTORNEY REPRESENTATION *(Complete only if represented by an attorney for this claim. Attorney will need to file a letter of representation.)*

ATTORNEY'S NAME *(Last, First, and Middle)*	TELEPHONE NO. FAX NO.	JURIS NO.	
ADDRESS	CITY	STATE	ZIP CODE

SECTION 5 STATISTICAL INFORMATION

HOW DID YOU FIND OUT ABOUT THE CRIME VICTIMS' COMPENSATION PROGRAM?

☐ POLICE
☐ POSTER/BROCHURE
☐ FRIEND/ACQUAINTANCE
☐ PHONE BOOK
☐ VICTIM ASSISTANCE PROGRAM
☐ PUBLIC SERVICE ANNOUNCEMENT
☐ MEDICAL PROVIDER
☐ SOCIAL SERVICE PROVIDER
☐ PROSECUTOR
☐ COMMUNITY ADVOCATE
☐ OVS STAFF
☐ OTHER _____
☐ HOSPITAL
☐ ATTORNEY
☐ OFFICE OF ADULT PROBATION

SUBMISSION OF INFORMATION REGARDING RACE/ETHNIC BACKGROUND OR DISABILITIES IS STRICTLY VOLUNTARY.

RACE/ETHNIC BACKGROUND

☐ WHITE
☐ ASIAN/PACIFIC ISLANDER
☐ BLACK
☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ HISPANIC
☐ OTHER

DISABLED PRIOR TO CRIME?

☐ YES
☐ NO

SECTION 11 HOMICIDE: FUNERAL EXPENSES

Are you applying for compensation for funeral expenses? ☐ Yes ☐ No If yes, complete the following.
Attach the funeral bill and a copy of the death certificate.

NAME OF FUNERAL HOME		TELEPHONE NO.	
ADDRESS	CITY	STATE	ZIP CODE

Have/will any funeral expenses be paid by any of the following sources?

Source	Yes	No	Source	Yes	No
Social Security	☐	☐	Life Insurance	☐	☐
Veterans Benefits/Insurance	☐	☐	Public Assistance	☐	☐
Burial Insurance	☐	☐	Other _____	☐	☐

SECTION 12 HOMICIDE: LOSS OF SUPPORT

Are you applying for Loss of Support Compensation? ☐ Yes ☐ No If yes, complete the following.

For a child, attach a copy of the child's birth certificate and, if applicable, Social Security Survivor Benefits statement. For a spouse, attach a copy of the marriage certificate. If an estate for the deceased has been opened, send a copy of the Appointment.

Dependent's Name	Date Of Birth	Relationship	Guardian (if Minor)

Have/will dependents receive benefits from any of the following sources?

Source	Yes	No	Source	Yes	No
Accident Insurance	☐	☐	Social Security Survivor Benefits	☐	☐
Life Insurance	☐	☐	Proceeds from Civil Action (Lawsuit)	☐	☐

SECTION 13 STATEMENT OF FACTS AND AUTHORIZATION

Fill in victim's or family member's name and **SIGN IN THE PRESENCE OF A PERSON AUTHORIZED TO TAKE ACKNOWLEDGMENTS**

The undersigned certifies that the information contained herein is true to his or her best knowledge, information and belief and hereby authorizes any hospital, physician(s) or other person(s) who attended or examined _____ , funeral director or other person(s) who rendered services, any employer(s) of the victim, any police or other municipal authority or agency, or public authorities including State and Federal revenue services, any Insurance Company or organization having knowledge thereof, to furnish to the Office of Victim Services or its representative any and all information with respect to the incident leading to the victim's or family member's personal injuries or death and this application made for compensation. A photocopy of this authorization will be considered as effective and valid as the original.

(Victim's or Family Member's Name)

SIGNED *(Applicant, parent or guardian if victim is a minor or an incompetent person).*	RELATIONSHIP TO VICTIM	DATE SIGNED
X		

Sworn and Subscribed before me on: _____
DATE SIGNED

_____
SIGNATURE, PERSON AUTHORIZED TO TAKE ACKNOWLEDGMENTS

(PLEASE USE SEAL)

Seal

SECTION 6 CRIME INFORMATION

TYPE OF CRIME: ☐ ASSAULT ☐ SEXUAL OFFENSE ☐ ROBBERY WITH INJURY ☐ OTHER _____
☐ DWI* ☐ HIT AND RUN* ☐ VEHICULAR MANSLAUGHTER* ☐ HOMICIDE *Be sure to complete Insurance information in section 10

BRIEF DESCRIPTION OF CRIME:

_____

_____

_____

_____

_____

Date of crime: _____ Time of crime: _____ ☐ a.m. ☐ p.m.
Address, City, State where crime occurred: _____
Was a weapon used? ☐ Yes ☐ No If yes, in what way? _____
Date crime was reported to police: _____ Who reported the crime? _____
Police department to which crime was reported: _____
Name(s) of assisting officer(s), if known: _____
If you did not report the crime to police within 5 days, explain why: _____
Has an arrest been made? ☐ Yes ☐ No ☐ Unknown
Name(s) of offender(s), if known: _____
Did the victim know offender(s)? ☐ Yes ☐ No
Was the victim living with offender(s) at the time of the crime? ☐ Yes ☐ No
Has the offender(s) been charged in court? ☐ Yes ☐ No ☐ Unknown
If yes, which Court? _____ Docket No., if known _____

SECTION 7 RESTITUTION/CIVIL ACTION

Did the Court order the offender to make restitution? ☐ Yes ☐ No ☐ Unknown If yes, complete the following.

RESTITUTION ORDER DATE	COURT	AMOUNT
		$
HOW IS IT TO BE PAID?		HOW MUCH HAS BEEN PAID?
		$

Have you filed or do you intend to file a civil action? ☐ Yes ☐ No ☐ Unknown If yes, complete the following.

Attach a copy of the complaint. If you have settled with a third party, attach a copy of the settlement.

NAME OF ATTORNEY	ADDRESS (Street, City, State, Zip Code)

SECTION 8 EMPLOYMENT INFORMATION

Are you applying for wage loss compensation? ☐ Yes ☐ No If yes, complete the following.
If you are self-employed, attach a copy of your income tax return for the year before the crime and the year of the crime.

VICTIM'S EMPLOYER		TELEPHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
SUPERVISOR'S NAME	NO. HOURS VICTIM WORKED PER WEEK	WAGE PER HOUR	TIPS/BONUSES PER WEEK
		$	$
DATES ABSENT FROM WORK DUE TO CRIME-RELATED INJURIES		TOTAL NO. HOURS ABSENT	
FROM: _____ TO: _____			
DOCTOR WHO CAN VERIFY LENGTH OF TIME VICTIM WAS UNABLE TO WORK		TELEPHONE NO.	
ADDRESS	CITY	STATE	ZIP CODE

Do/Did you receive financial support from any of the sources listed below?

Source	Yes	No	Source	Yes	No
Sick Leave	☐	☐	Workers Compensation	☐	☐
Vacation	☐	☐	Unemployment Compensation	☐	☐
Union/Fraternal Insurance	☐	☐	Other _____	☐	☐
Disability Benefits	☐	☐			

SECTION 9 MEDICAL/COUNSELING INFORMATION

Are you applying for compensation of medical, dental, or mental health counseling expenses? ☐ Yes ☐ No

If yes, complete the following and, if available, enclose original bills.

Brief description of physical or emotional injuries that resulted from the crime: _____

_____

List all providers who gave treatment. Include hospitals, doctors, dental providers, mental health counselors, ambulance, radiology and prescriptions (drugs and eyeglasses). **Attach additional sheets if necessary.**

Provider's Name	Street Address	City, State, Zip	Telephone No.

Will there be additional medical treatment? ☐ Yes ☐ No ☐ Unknown If yes, Provider's name: _____

SECTION 10 INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Have/will any bills be paid by any of the following sources?

Source	Yes	No	Source	Yes	No	Source	Yes
Yourself	☐	☐	Veterans Administration	☐	☐	Other _____	☐
Private Health Insurance*	☐	☐	Life Insurance	☐	☐	Other _____	☐
Medicare	☐	☐	Auto Insurance	☐	☐		
Medicaid	☐	☐	Workers' Compensation	☐	☐		

*Attach "Explanation of Benefits" statements, if available

NAME OF PRIMARY MEDICAL INSURER	POLICY NO.	TELEPHONE NO.
NAME OF SECONDARY MEDICAL INSURER *(if applicable)*	POLICY NO.	TELEPHONE NO.

Do/Did you receive assistance from any of the following sources?

Source	Yes	No	Source	Yes	No
Social Security	☐	☐	Dept. of Children & Families	☐	☐
City Public Assistance	☐	☐	Soldiers, Sailors, Marines	☐	☐
State Medicaid	☐	☐	Other _____	☐	☐

Did the crime involve motor vehicle(s)? ☐ Yes ☐ No If yes, complete the following.

MAKE/MODEL OF **OFFENDER'S** VEHICLE	NAME OF VEHICLE'S REGISTERED OWNER		
ADDRESS OF REGISTERED OWNER	CITY	STATE	ZIP CODE
REGISTERED OWNER'S AUTO INSURER	POLICY NO.	TELEPHONE NO.	
MAKE/MODEL OF **VICTIM'S** VEHICLE	NAME OF VEHICLE'S REGISTERED OWNER		
ADDRESS OF REGISTERED OWNER	CITY	STATE	ZIP CODE
NAME OF REGISTERED OWNER'S AUTO INSURER	POLICY NO.	TELEPHONE NO.	

Has settlement been made with insurance carrier(s)? ☐ Yes ☐ No If yes, complete the following.
Attach a copy of the settlement.

NAME OF CARRIER	NAME OF CARRIER